

Prescription Drug Misuse and Overdose Prevention and Pain Management Advisory Council

NOTES from 1/9/2015 Meeting

MEETING FACILITATOR: Mike Landen, DOH

ADVISORY COUNCIL MEMBERS PRESENT: Mike Landen, Steve Jenkusky, Bill Barkman, Frances Lovett, Steven Seifert, Ernie Dole, Margreet Jenness, Joanna Katzman, Jennifer Weiss, Julie Muche

OTHER PARTICIPANTS: Paul Balderamos, Daniel Still, Cecilia Roberts, Sandra Adondakis, Harris Silver, Toby Rosenblatt, Laura Tomedi, Jim Davis, Luigi Garcia Saavedra, Maureen Wilks, Valerie Fisher, Nicole Casados, Elaine Brightwater, Carl Flansbaum, Melissa Heinz, Cheranne McCracken, Frank Koronkiewicz, Sharon Suan, Valerie Hanway, Monique Dodd, Rebecca Leppale

1. Introductions and Review of Agenda
2. Review of December 2014 Meeting Notes
 - Began review on recommendations last month
3. Count of voting members at table – we have quorum.
4. Consent Calendar Review
 - Carl: proposed removal of #5, the “Report Card” recommendation. No objection.
 - Mike: proposed removal of #7, recommending revision to Drug and Cosmetic Act for naloxone storage – may be able to be accomplished with rule/regulation. No objection
 - Call for vote on consent calendar recommendations (1, 2, 3, 4, 6, and 8) – All in favor, no objections and no abstentions.
5. Further modification to Recommendation #5 (Report Card including naloxone and overdose prevention patient education guidance providers)? Julie M. agrees to removal of the recommendation entirely.
6. Further modification to Recommendation #7 (statute revision to clear naloxone storage impediment for community-based overdose prevention initiatives)?
 - Steve J.: Could we revise to call for rule revision rather than statute revision?
 - Mike: Add “community-based overdose prevention efforts” in front of “public safety” on Recommendation #3 from Consent Calendar? All in favor, no objections and no abstentions.
7. Recommendations for Further Discussion
 - #1 – “All licensing boards whose members include controlled substance prescribers should monitor the utilization of the PMP by their licensees in accordance with board rules.”
 - o Steve J. – This would be dependent upon available staff time – We already do this once a provider is on our radar – Also this would be subject to the Board of Pharmacy

giving us the information as well as staff time (4,000 licensees)

- o Joanna – concerns that this would result in some providers being reviewed and others not – unless all are monitored at same frequency.
 - o Steve J. – maybe we could handle it the way we do with CME audits – checking into 10% of those who report CMEs for proof of completion.
 - o Joanna – concerned with potential unintended consequences ... and if we are investigating the “top 20 over-prescribers” will we also be investigating the “top 20 UNDER-prescribers”?
 - o After further discussion, Mike L. proposed the following: All licensing boards (whose members include controlled substance prescribers) should develop a process to monitor the utilization of the PMP by their licensees in accordance with board rules.” Call for vote with this revision to original recommendation – All in favor, no objections and no abstentions.
- Recommendation #2: “All hospital emergency departments and acute care settings should have prescribing guidelines for opioids to reduce the misuse of controlled substances by patients presenting in those settings.”
 - o Mike – We passed similar recommendation in 2012 (Tabled)
- Recommendation #3: “All licensing boards whose members include controlled substance prescribers should publish the list of their prescribing members who have accessed the PMP, and those who have not, on a quarterly basis.”
 - o No member wants to proceed with this recommendation at this time.
- Recommendation #5: “The Governor should collaborate with neighboring states to improve prescription opioid policy (PMP) and standards.”
 - o Following brief discussion, decision was made to drop this recommendation.
- Recommendation #6: “(Responsible party should) conduct an anonymous survey of chronic pain patients to address what their needs might be and learn more about this patient pool.”
 - o Introduced by Maureen W. – very little from this Council is focused on pain management side of the picture ... effect on pain patients and how many pain patients may be benefiting from prescription opioids .. emphasis always on harm caused ... we need to understand more about this patient pool in order to move forward with good policy.

- o Mike – proposed friendly amendment to identify state agency or entity (state legislature?) to agree to fund the survey.
 - o Revision: “The DOH and UNM HSC should conduct an anonymous survey ...” Call for vote – All in favor, no objections and no abstentions.
- Recommendation #7: “The Office of Medical Investigator should provide more detail in their drug overdose death data (mental health/suicide markers).”
 - o Introduced by Maureen W.
 - o Mike – the data are there ... the issue is having a staff person extract the data.
 - o Melissa H. – We have discussed this in the past ... possibility of a mortality review panel for drug overdose?
 - o Laura T. – Case fatality review with the national violent death reporting system – 30+ states, including OMI records and public safety, etc info. We have had discussion around adding an Overdose Death module.
 - o Mike – proposed following revision: “OMI and DOH should implement a Drug Overdose Death module in the NVDRS” Call for vote: All in favor, no objections and no abstentions.
- Recommendation #4: Medical Cannabis
 - o Steve S. – power point presentation last month – time constraints today but I will summarize: historical basis and theoretical basis for its efficacy. Study suggesting reduction in opioid overdose death rates. Use of cannabis may accomplish reduction in OD deaths. I crafted the recommendations as flexibly as I could such that each individual board could take steps that were within legal bounds. Shared these with the Medical Cannabis Program Medical Advisory Board, “heartily endorse the recommendations and will look forward to future collaboration ...”
 - o Steve J. – I think this would be grossly irresponsible to recommend use of marijuana – hazards of using marijuana.
 - o Joanna K. – study cited (meta analysis on medical cannabis programs associated with reduced misuse/overdose with prescription opioids) is faulty
 - o Steve J. – Medical Advisory Board for the Program approved PTSD (as qualifying condition) without evidence. If we as a Council are going to become complicit in the misuse of medical cannabis, I would resign.

- o Paul B – Concern about level of THC and very concerned about adolescents. More investigation is needed.
- o Jennifer – medical cannabis may lead to loss of federal program support such as disability. Also concerned with teenagers and association with increased substance use among teens.
- o Joanna K. – I believe in efficacy of cannabinoid in treatment for chronic pain and I think it needs to be studied – particularly with epilepsy. But all of our largest medical societies are against medical cannabis treatment.
- o Julie M. – From our controlled substance guidelines from ABQ Partners. We do not endorse unless for hospice and ALS and HIV/AIDS. Prescription cannabinoids in our guidelines.
- o Steve S. – I hear strong emotion but many of the points being raised do not relate directly to my recommendations. Bottom line: use of cannabinoid may prevent the need to pursue opioid pain medication – when they are used lower dosing of prescription opioids can be used. Even patients who “abuse” cannabis have had effect on chronic pain. I argue for optimal use of existing program.
- o Julie M. – I am a chronic pain physician – patients who are on medical cannabis, our guidelines call for weaning off of opioids – and most of all of our patients choose the opioids over cannabis.
- o Steve S. – clearly opioids ALONE are more effective than cannabis alone – so you have set up an artificial choice with your guidelines.
- o Elaine – what about education – the concern is around suggesting that providers consider cannabis PRIOR.
- o Mike: Medical Marijuana is a reality – increasing enrollments all the time. One choice is to do nothing and another is to educate patients about its existence. What about delete c and d. delete medical cannabis from the header.
- o Ernie D. – Do we know enough ... have enough evidence to recommend medical cannabis?
- o Sandra A. – while American Cancer Society does not have position on medical cannabis overall, concerned about smoking.
- o Maureen: I do believe that there is a place in pain management for medical cannabis – not across the board. The quality of the life right now is what’s worth the relief now. Sometimes the quality of life is the primary concern.

There are places where it is inappropriate but also where it is appropriate.

- o Harris: I'm a patient, too – no one told me about the risks of opioid – nobody talks about side effects of opioids to me – psychiatric side effects, for example
 - o Cheranne – concern around the conflicts with Board rules.
 - o Carl F. – Seems to be a shift from a policy recommendation to a clinical recommendation ...
 - o After further discussion, Steve S. requested votes on each point (5 parts)
 - o Mike L. – Point b: “boards recommend that providers consider non-opioid & non-pharmacological treatment before opioids are prescribed in chronic, non-cancer pain patients.” Call for vote: 8 in favor, 2 opposed, 0 abstaining. Passed.
 - o Steve: points ‘a’ and ‘e’ as a package, just as written. Call for vote: 2 in favor, 8 opposed. Failed to pass.
 - o Steve: ‘c’ and ‘d’ as a package. 1 in favor and 9 opposed. Failed to pass.
- Recommendation #8: Abuse Deterrent Formulations
 - o Introduced by Cecelia/Pfizer. Recommendations for parity on out of pocket cost so that neither physician nor patient faces cost barrier – Second recommendation that the generic option not be extended. Many states pursuing this approach.
 - o Harris – the first recommendation is great – encourage others for parity, too.
 - o Ernie – I'm not sure if these really reduce abuse. And I don't really understand the parity issue.
 - o Steve J. – How much more expensive is the abuse deterrent – would your company consider assigning a lower price and not assure their own profit? And concerns with representative from the pharmaceutical industry at this table.
 - o Joanna K. – what about recommendation that we educate providers about abuse deterrent formulations – this removes the industry bias.
 - o Ernie D. – I don't think there's enough data out there yet – not enough time. I think the theory is good. But I think having a brand name/insurance company define how we go – making a recommendation without sufficient evidence.
 - o Further discussion from multiple council members
 - o Mike L. – Acknowledge concerns from Council members on procedural issue posed by industry representative

proposing recommendation and concern over appearance of voting down a recommendation on ADF, which most are supportive of. Call for vote on tabling the recommendation: All in favor, no objections and no abstentions.

- o Dan Still - Everyone at table represents a group with a bias ... Is there a requirement that those with some bias can speak and others cannot?
- o Mike: No, we just made the decision to table the recommendation. We'll talk next meeting about who can put forward recommendations, etc.

Next meeting: Friday, April 3, 2015, 1:30 pm to 3 pm